UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

# AGE and/or QUANTITY OVERRIDE

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Pharmacy NPI#:_____Strength:_____Frequency/Day:_____

**All information to be legible, complete and correct or form will be returned**

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## FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

## **For Stimulant drugs, please use the Stimulants PA sheet**

*In special circumstances, Utah Medicaid may consider exceptions to a drug's age or quantity limits, when requested. Please note that submission of this Prior Authorization Request Form does not guarantee approval.*

**CRITERIA:**

Explanation of rationale for requesting the override, including previously tried and failed drugs.

**AUTHORIZATION:**
Variable, according to the agent requested (most often 6 months to 1 year)

**RE-AUTHORIZATION:**
Updated letter of medical necessity

04/13/2012